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# THE IMPLEMENTATION OF THE HEALTH SYSTEMS AGENCY IN MONTANA

Thomas L. Judge, Governor
Michael G. Billings, Director

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# THE IMPLEMENTATION OF THE
# HEALTH SYSTEMS AGENCY
# IN MONTANA

April 1, 1976

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# I N T R O D U C T I O N

The passage of PL 93-641, the National Health Planning and Resource Development Act of 1974, and the subsequent designation of Montana as a single health service area has mandated a restructuring of the existing health planning and resource development system in Montana. The legislation requires the establishment of a Health Systems Agency (HSA) for each health service area in the nation and a State Health Planning and Development Agency (State Agency) for each state. The designation of Montana as a single health service area will result in the establishment of a non-profit private HSA in Montana. Existing programs such as Comprehensive Health Planning, Regional Medical Programs, and Hill-Burton will be phased out as the new agencies are designated.

To insure a smooth and successful transition into the national system of health planning and resource development specified by PL 93-641, consideration must be given to the implications of this law as it specifically relates to Montana. The Department of Health and Environmental Sciences which has played a major role in the development of the existing health planning system in Montana must define its appropriate relationship to the non-profit corporation which is to become the Health Systems Agency (HSA) for Montana.

This report is designed to acquaint the general public, the legislature, service providers, consumers, and government officials with existing health planning activities in Montana and to outline anticipated, future changes in these programs. Limitations of time and space prohibit saying everything that could or should be said about health planning in Montana or the anticipated impact of the National Health

Planning and Resource Development Act of 1974. Also, since implementation of the Act is in process, the report only discusses the major constituent elements of the legislation and major implications for Montana. A detailed picture of how the Health Systems Agency and Department of Health and Environmental Sciences finally will interface under the provisions of the Act will become available only as the federal government issues administrative guidelines and as the Health Systems Agency and Department of Health and Environmental Sciences negotiate a mutually satisfactory division of labor.

# PART I

# THE BACKGROUND OF THE EXISTING HEALTH AND PLANNING AND RESOURCE DEVELOPMENT SYSTEM IN MONTANA

Chapter 1

# COMPREHENSIVE HEALTH PLANNING

## Legislative Background

The Comprehensive Health Planning (CHP) program began with the passage of the Public Health Services Amendments of 1966 (PL 89-749) authorizing a two-year program to establish state and areawide Comprehensive Health Planning Agencies. The legislation emerged from the health facilities planning committees established under the Hill-Burton program. There was a concern that facility planning, without health manpower and services planning, would lead to the establishment of health facilities which might not address specific local health needs.[1]

Section 314(a) of PL 89-749 provided formula grants to states for the establishment of State CHP Agencies to administer the State's health planning program. Each State CHP Agency was to be advised by a health planning advisory council which included "representatives of State and local agencies and non-governmental organizations and groups concerned with health and consumers of health care" (PL 89-749). The law specified that "...a majority of the membership of such council shall consist of consumers" (i.e., purchasers of health services). Project grants were made available to public or private non-profit organizations interested in establishing areawide health planning agencies under Section 314(b) of the Act. Section 314(c) provided project grants to institutions for training studies and demonstrations designed to develop and improve

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[1] Report No. 93-1382 Report by the Committee on Interstate & Foreign Commerce, September 26, 1974.

comprehensive health planning.

The original legislation was amended in 1967 through the Partnership for Health Amendments and required: 1) State CHP Agencies to assist facilities in developing programs for capital expenditures, 2) States to provide one-quarter (¼) of the costs of the state health planning efforts, and 3) local governments to be represented on the CHP Advisory Council.

In 1970, the CHP legislation was amended again and required areawide councils to include representatives of health care facilities. The legislation also stipulated that grant applications for federally funded projects be reviewed by areawide agencies to determine whether proposed services were consistent with State and areawide health plans.

The role of CHP Agencies was strengthened by passage of the Social Security Amendments of 1972 (PL 92-603), which added Section 1122 to the Social Security Act. The Section specified facilities would not be reimbursed by Medicare, Medicaid or the Maternal & Child Health Programs for depreciation, interest or return on equity capital relating to capital expenditures if the facilities were deemed inconsistent with standards, criteria, or plans developed in each state. This was the first attempt to relate health financing to planning and to give the CHP agencies some authority for decision making.

Implementation in Montana

Montana's experience with CHP began on October 28, 1966, when Governor Tim Babcock designated the Montana State Board of Health* as the

*After Executive Reorganization in 1971, these responsibilities came under the Department of Health and Environmental Sciences.

single state agency for comprehensive health planning as required by PL 89-749. The "Plan for Planning", a document which outlined the structure of the agency, the membership of the Advisory Council for Comprehensive Health Planning, and the work program for fulfilling the functions as a 314(a) agency, was prepared by the Comprehensive Health Planning (CHP) Division and approved by the U. S. Public Health Service on February 5, 1968.

The initial efforts of the CHP Division were directed toward defining the scope of the proposed Health Planning program, developing the expertise of the staff and council members, and organizing regional interests to prepare for the establishment of areawide health planning agencies. The State CHP office was instrumental in the establishment and initial funding of the areawide CHP Agencies. A great deal of time was spent identifying local people with an interest in health planning, organizing representative regional councils and the subsequent non-profit private organizations that were to become areawide health planning agencies, securing local match funds, and assisting with the preparation of grant applications for federal money.

The first areawide agency to receive federal funds was the Southwestern Areawide Health Planning Council funded in July 1971. With the 1973 designation of the Economic Development Association of Eastern Montana as the areawide health planning agency for the 17 eastern-most counties, Montana added the last of its five areawide health planning organizations.

Some of the areawide organizations grew out of existing structures concerned with health facilities planning. Changing the existing

organizational thrust involved broadening geographic representation on the areawide councils and expanding the focus of the organization to include planning for health services and manpower as well as health facilities. The first years of the areawide organizations were primarily directed at developing and sustaining citizen interest in community health planning. The five areawide organizations developed as distinct entities, each with a unique planning approach to meet the particular needs of its area. Major activities undertaken by the areawides, often with the assistance of the State CHP Office, included:

1. Publicizing CHP as a program and stimulating interest in local areas. Some areawides organized county health planning councils.

2. Identifying the perceived health needs of their areas, ranging from health manpower shortages to a lack of coordination of existing services.

3. Conducting reviews of capital expenditures for health facilities and making recommendations to the Designated Planning Agency (following enactment of 1122 review process).

4. Assisting local communities in meeting health care needs. Efforts included: assisting communities in their attempts to attract health manpower, supporting efforts to obtain local funding for health projects, and preparing plans or grant applications for federal and other funding sources.

5. Preparing areawide health plans. By February 1976, four of the five areawide organizations had developed health plans which addressed the health needs of each area. The plans varied in structure and scope but each presented a compilation of pertinent health data, an inventory of existing services, and projections of future health needs.

Implementation of the National Health Planning and Resources Development Act of 1974 (PL 93-641) in Montana will result in the termination of the CHP program. PL 93-641 stipulates that the 314(b) agencies are to be terminated within three months of the Secretary of HEW's designation of a Health Systems Agency (HSA) for Montana. The state office of CHP

is to be terminated within three months of the designation of the State Health Planning and Development Agency. Current funding for these organizations will expire on June 30, 1976.

Accomplishments and Shortcomings of CHP

A series of interviews conducted prior to preparation of this report sought information regarding the more significant accomplishments and short-comings of the Comprehensive Health Planning Program, the Regional Medical Program and the Hill-Burton Program.

Respondents (see Appendix A) saw the initiation of "grass roots" involvement in health planning through the areawide organizations as a significant accomplishment of the CHP program. The county and regional organizations developed a cadre of citizens informed about health and health care planning, and established a forum where health consumers and providers could cooperatively grapple with health problems and propose meaningful solutions. Before CHP, providers of health care were almost solely responsible for decisions made in the health care field. With the establishment of areawide organizations and the passage of Section 1122 of the Social Security Act, a system was established for soliciting citizen input to health care needs and for "tracking" public expenditures for health care. Providers of health care were given an opportunity to be more responsive to the unique needs of the communities they served.

The effectiveness and overall success of the CHP program is a topic of national debate. In Montana, major shortcomings were identified in three areas: funding levels, lack of authority, and the lack of direction from the federal and state levels.

CHP programs across the country, and in Montana, suffered from a lack of funds. This shortage made it difficult to attract and retain qualified staff. Staffing levels were often inadequate for fulfilling the variety of functions undertaken by planning agencies such as review activities, comprehensive planning, community organization, and response to local requests. The broad mandate of the CHP legislation made it difficult for agencies to identify priority concerns. There was a significant lack of direction from responsible federal and state agencies, a condition aggravated by the "idealistic" comprehensive definition of health planning contained in the enacting legislation. There was, as well, a noticeable lack of conformity among the five areawide councils. Different levels of funding and staff resulted in varying degrees of accomplishment.

The CHP program was to prepare plans to eliminate deficiencies in the health care delivery system but was not provided the authority to implement those plans. Even the 1122 review process lacked sufficient authority since the sanction for failing to comply with a review decision was the loss of a small portion of the Medicaid and Medicare reimbursement. For larger institutions this sanction constituted only a minor loss of income.

Another shortcoming of the CHP program was a lack of credibility. Lacking authority, limited in staff and, in many cases, having only minimal involvement with health care providers, the CHP agencies were often considered an ineffective planning organization. Often their role as an advocate of the public interest involved them in controversial issues and pitted them against groups whose cooperation was vital to the success of the program.

Chapter 2

# REGIONAL MEDICAL PROGRAMS

## Legislative Background

The Regional Medical Program (RMP) was established by the Heart Disease, Cancer and Stroke Amendments of 1965 (PL 89-239) which added Title IX to the Public Health Service Act. The legislation was prepared in response to the 1974 Report of the President's Commission on Heart Disease, Cancer and Stroke which recommended the establishment of a national network to develop linkages between local diagnostic and treatment stations, regional centers and medical complexes, in an attempt "to unite the worlds of scientific research, medical education and medical care".[2] The program's concept was to provide a vehicle for transferring scientific knowledge about the diagnosis and treatment of cancer, stroke, and related diseases to health care providers and thereby improve the quality of care.

In 1970, the RMP legislation was extended through the enactment of PL 91-515. PL 91-515 added the treatment of end-stage renal disease as a priority of RMP's and expanded on the strict categorical disease emphasis by stressing the development of linkages between primary health care and secondary and tertiary care. PL 91-515 also promoted the funding of projects designed to improve the use, productivity, and distribution of health manpower, especially in under-served areas. In an attempt to coordinate the work of the RMP's with CHP agencies, the legislation

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[2]Report No. 93-1382 Report by the Committee on Interstate and Foreign Commerce, September 26, 1974.

specified that the areawide CHP agencies be allowed to review and submit comments on RMP grant proposals affecting their areas.

In 1974, the President's budget did not request further funding for RMP. However, Comgress was initiating its study of health planning and resource development and proposed the extension of all expiring program authorities with the Health Program Extension Act of 1973 (PL 93-45). The Regional Medical Programs are scheduled to expire, however, following the establishment of HSA's.

Implementation in Montana

There were two Regional Medical Program funding projects in Montana. The Intermountain Regional Medical Program (IRMP), whose central office was in Salt Lake City, provided limited funding to projects in the southwestern corner of the state. The Mountain States Regional Medical Program (MSRMP) covered the entire state and generally had a greater effect on health care activities in Montana.

Under the original RMP legislation, each RMP was required to have a sponsoring fiscal agent. In most states, a medical school acted as program sponsor. However, in 1966, the states of Idaho, Wyoming, Nevada and Montana did not have a medical school. So, representative groups in these states banded together and asked the Western Interstate Commission for Higher Education (WICHE) to act as sponsor for a Regional Medical Program*. From this coalition, the Mountain States Regional Medical Program (MSRMP) was established.

In November 1966, an MSRMP division office was established in Great

*WICHE is a program which provides financial and other assistance allowing students from states which are without health profession schools to attend such schools in other areas.

Falls, Montana. In its first two years, MSRMP directed its efforts toward conducting an extensive health survey of the four states, identifying the needs of health care professionals and consumers, and determining available health resources. As a result of this activity, MSRMP embarked on two principal programs. First, MSRMP established a coronary care training program for nurses and physicians from rural areas. Second, it created the Montana Medical Education and Research Foundation (MMERF) to provide continuing education programs for all health professionals. MSRMP, in conjunction with MMERF, was instrumental in providing necessary educational opportunities for health care professionals in Montana. The MSRMP also funded: nursing assessment workshops for training nurses to identify the major health problems of patients; the development of regional health training centers, using Montana's seven hospital districts as a network for providing training programs, for all hospital employees; and cancer screening programs which provided training to physicians and nurses while screening portions of the population for cancer. After 1970, when the scope of the RMP legislation was expanded, MSRMP supported programs aimed at improving emergency medical services, newborn intensive care, and nurse practitioner training.

On June 30, 1976, the funding for the RMP's is scheduled to expire. MSRMP has formed a non-profit private corporation, Mountain States Health Corporation, which will seek funds from public and private sources to carry on the type of activities funded by MSRMP in the past.

Accomplishments and Shortcomings

Those interviewed generally agreed that MSRMP, and to a lesser extent, IRMP, provided a valuable mechanism for delivering educational programs

to health care professionals. In a rural state like Montana, with limited access to medical schools, health professionals previously had to travel great distances for educational opportunities. MSRMP attempted to bring educational programs to rural areas. It also provided educational programs to health professionals previously ignored, such as laboratory technicians, medical records administrators, etc.

The educational focus of MSRMP and MMERF provided the impetus for the establishment of formal health care educational programs through Montana colleges and universities. MSRMP was involved in the establishment of the WAMI Program*, the Family Nurse Practioner Program at Montana State University and the Medical Records Administration program at Carroll College.

The RMPs were established as developmental programs with no formal relationship to health planning programs. Many local health planners complained that RMP projects did not always address priority problems of the communities. The relationship of CHP and RMP was often one of rivalry, resulting in an inability to coordinate the planning of CHP with the implementation activities of RMP.

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*The WAMI Program (an acronym for the four participating states of Washington, Alaska, Montana and Idaho) permits states without medical schools to avoid prohibitive construction costs by using existing facilities (in our State, Montana State University) and by utilizing community physicians as medical faculty. Students are permitted to take the first portions of their medical training at MSU, and then transfer to the University of Washington School of Medicine for the balance of their basic curriculum.

Chapter 3

# HILL-BURTON PROGRAM

## Legislative Background

Following World War II, the U. S. was faced with a shortage of hospital beds, a condition aggravated by the unequal distribution of beds between urban and rural areas. To identify and address the shortages and disparities, Senators Hill and Burton introduced PL 79-725, the Hospital Survey and Construction Act of 1946. The legislation established what is commonly referred to as the Hill-Burton Program, a federal/state partnership designed to survey needs, develop state plans for the construction of non-profit hospitals, and assist in constructing and equipping such facilities.

Authorization for the Hill-Burton Program has continued to the present. In 1964, the program was modified with the enactment of the Hospital and Medical Facilities Amendments of 1964 (PL 88-443). The legislation extended authorization for existing construction categories while adding authorization for long-term care or nursing home facilities. PL 88-443 also established a new grant program for the modernization or replacement of health facilities. In 1970, the Medical Facilities Construction and Modernization Amendments (PL 91-296) which supplemented the grant program with a program of loans and loan guarantees was passed over President Nixon's veto. This legislation mandated that priority be given to those geographic areas with relatively small financial resources and to rural communities. Priority was also given to the establishment of

out-patient facilities in poverty areas, facilities providing comprehensive care, training in the health professions, and treatment for alcoholism. The functions of the Hill-Burton Program precluded in PL 93-641 to better coordinate facilities planning with health manpower and services planning. Currently there is an excess number of health care beds in the nation. The emphasis in Title XVI is directed away from construction of inpatient facilities (except "in areas of recent rapid population growth") and toward the construction of out-patient facilities and the conversion or modernization of existing facilities.

Implementation in Montana

Unlike the CHP and RMP programs, the history of the Hill-Burton program in Montana is quite extensive and considerably less controversial. In 1948, the Montana State Board of Health* was designated as the single state agency for administration of the Hill-Burton Program. The Construction Bureau of the Department of Health and Environmental Sciences was assigned the responsibility for Hill-Burton. The first recipient of Hill-Burton funds was Glacier County Memorial Hospital in Cut Bank, Montana, which received $101,404.72. Since that project, the Hill-Burton Program has provided over 18 million dollars for hospital construction.

In 1965, the Hill-Burton Program was expanded to include the issuance of grants for the construction of long-term care (nursing home) facilities and modernizing existing health care facilities. Hill-Burton agencies were required to use new criteria (utilization, population and occupancy) in determining the need for new or re-modeled facilities. Each state Hill-Burton agency was provided with federal allotments to implement

*Refer to note on page 2.

priority projects established in the annual State Plan for Hospital and Medical Facilities Construction.

In August 1975, the Construction Bureau combined with the CHP Division to form the Health Planning and Resource Development Division in preparation for the implementaion of PL 93-641. The Division's Resource Development Bureau will be responsible for administering Title XVI of PL 93-641 when implemented.

Accomplishments and Shortcomings

Nationally, the Hill-Burton Program provided funds for needed hospitals and other medical facilities. Of particular importance to Montana was the emphasis on the establishment of adequate medical facilities in the rural areas. Many rural areas would not yet have a hospital or nursing home were it not for the Hill-Burton Program. In addition, the program was instrumental in elevating the standards of health facilities design, construction, and operation through the review of proposed facility construction plans to assure consistency with State and national standards.

The Hill-Burton Program was established to increase the capacity of the nation's health facilities. However, during the program's thirty-year experience, the need for additional hospital beds has virtually disappeared and recent data indicates a national surplus of 20,000 to 60,000 hospital beds. Empty beds are costly to facilities and that cost is often reflected in charges to the consumer. Critics of the Hill-Burton Program suggest that Hill-Burton funds were partially responsible for the current surplus of hospital beds.

In Montana, many small rural hospitals built with Hill-Burton funds

now experience low occupancy and are in a constant struggle to meet the cost of operation. Many of the facilities are so small they can only provide primary care, necessitating travel to the larger hospitals for everything but the most routine procedures. Many of these small rural hospitals may be unnecessary because of changing health care delivery patterns and better transportation systems. Linking health planning with the Medical Facility Construction Program should help reduce the problem.

# PART II

# THE NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT OF 1974

(PL 93-641)

Chapter 4

# MAJOR PROVISIONS OF THE NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT

The National Health Planning and Resource Development Act of 1974 established a national system of integrated health planning, supported by a strong resource development capability. The purpose of the Act is "to facilitate the development of recommendations for a national health planning policy; to augment areawide and state planning for health services and to authorize financial assistance for the development of resources to further that policy". /PL 93-641, Section 2(b)/

The legislation establishes Title XV and XVI of the Public Health Service Act. Title XV calls for the development of a National Council on Health Planning and Development to advise the Secretary of Health, Education and Welfare (hereafter referred to as the Secretary), regarding the development of guidelines concerning national health policy and the implementation of the Act.

The legislation outlines specific criteria for the designation of health service areas throughout the nation. The Governor of each state is charged with the responsibility of designating the health service areas after consideration of the established criteria and the opinions of the existing CHP and RMP agencies in each state. A minimum population of 500,000 per health service area was established although waivers could be granted by the Secretary in "unusual" and "highly unusual" circumstances. The State of Montana was designated as a single health service area in

June 1975.

Each health service area is to contain a Health Systems Agency (HSA) which can be a non-profit private corporation, a public regional planning body, or a single unit of general local government whose area of jurisdiction is identical to the health service area. The HSA is designated by the Secretary of HEW after considering the recommendation of the Governor. An HSA is to be governed by a body of 10-30 people although the governing body can exceed 30 persons if an executive committee is established with powers to act for the full governing body. In an effort to insure broad representation, the legislation is very specific about the governing body's membership. (See Appendix B.) The governing body of the HSA may establish sub-area councils to advise it in the performance of HSA functions.

The functions of the HSA defined in Section 1513 of PL 93-641 are summarized below:

1. Assemble and analyze health data related to the health status area and the area's health care delivery systems.

2. After considering recommended national guidelines--establish, annually review and amend, as necessary, a Health Systems Plan (HSP), which shall be a detailed statement of goals describing a "healthful environment and health systems in the area which, when developed, will assure quality health services available and accessible in a manner that assures continuity of care, at a reasonable cost for all residents."

3. Prepare an Annual Implementation Plan (AIP) which describes objectives which will achieve the goals of the HSP and identify priorities among objectives.

4. Develop and publish specific plans and projects for achieving the objectives of the AIP.

5. Implement planned objectives through technical assistance and direct grants from the Area Health Services Development Fund which is provided to HSA's when an HSP and AIP has been approved by the Secretary (maximum grant - $1 per capita.)

6. Review and approve or disapprove proposed uses of funds appropriated under the Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.*

   - HSA's have 60 days to review. If funds are disapproved, the Secretary may not make funds available until he has made, at the request of the entity making the proposal, a review of the HSA decision. If he overrides the HSA decision he must submit a written statement of the reasons for his decision.

7. Coordinate activities with the Professional Standards Review Organization, A-95 review agencies, and other related agencies.

8. Assist the State Health Planning and Development Agency in conducting Section 1122 and Certificate of Need reviews.

9. Review on a periodic basis (and within three years from enactment) all institutional health services and make recommendations to State Agency regarding their "appropriateness".

10. Recommend to State Health Planning and Development Agency projects for the modernization, construction and conversion of medical facilities which will meet the goals of HSP and AIP.

The legislation also establishes a State Health Planning and Development Agency (State Agency), to be an arm of state government appointed by the Governor and responsible for performing the following functions, (PL 93-641, Section 1521):

1. Conducting the health planning activities of the State, preparing and revising a preliminary State Health Plan, and implementing those parts of the mandated State Health Plan which relate to the government of the State.

2. Administering and making determinations for the mandated Certificate of Need Program and the Section 1122 agreement with DHEW, regarding health providers' capital expenditures under that section of the Social Security Act.

3. Administering the State's Medical Facilities Construction (Hill-Burton) Program of grants and subsidies for public and private health facilities projects under Title XVI of PL 93-641.

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*An HSA shall not review and approve or disapprove proposed use of federal funds by an Indian tribe or inter-tribal organization, but will conduct review and comment.

4. Reviewing, at least once each five years, with the assistance of the HSA, "all institutional health services" offered in the State for "appropriateness" and making public reports of its findings.

5. Providing staff support to the Statewide Health Coordinating Council (SHCC), a citizens' advisory council, regarding state health planning activities. At least 60% of the SHCC is made up of HSA representatives. The SHCC is responsible for:
   a. Interfacing the Health Systems Plan with the preliminary State Health Plan.
   b. Reviewing HSA budgets and grant requests.
   c. Reviewing and approving or disapproving any State Plan or application submitted to HEW as a condition to the receipt of funds under allotments made to states under the Public Health Service Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.
   d. Advising the State Agency on the performance of its functions.

6. Collecting, analyzing and publishing statistical and other information related to health and health care (including a mandated program to "...require providers of health care...doing business in the State to make statistical and other reports..." to the State Agency).

7. Serving as an advisory body to HEW in instances where an HSA has disapproved a local provider's federal grant application and an appeal is filed.

As the preceding lists of responsibity indicate, in Montana, where there is a single HSA, a potential exists for duplication of effort between the HSA and the State Agency. Regulations published on October 17, 1975, regarding the HSA are silent on this point.

Chapter 5

## THE NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT (PL 93-641) COMPARED WITH LEGISLATION CREATING COMPREHENSIVE HEALTH PLANNING AND REGIONAL MEDIAN PROGRAM

A brief comparison of PL 93-641 with the CHP and RMP enabling legislation reveals that PL 93-641 is much more specific about program structure and operation than is the earlier legislation. The establishment of the National Council for Health Policy mandated by PL 93-641 is the first attempt to provide a mechanism for identifying national health goals to be used as a framework for HSA planning throughout the nation. This Council is to provide the conceptual guidance to the planning agencies that has been absent in the past. Also, to enhance the guidance and direction of the federal government, specific provisions in PL 93-641 call for the establishment of Centers for Health Planning which are to provide special health planning expertise to the HSA's and the State Agencies. PL 93-641 will also establish area health planning organizations (HSA's) across the country. Previously, the location of 314(b) agencies (i.e., local areawide CHP's) was haphazard and unequally distributed, although this was not a significant problem in Montana. In an attempt to create more uniformity among Health System Agencies, PL 93-641 specifies categories of members which must be represented on the HSA Governing Board, unlike the CHP and RMP legislation.

Another improvement designed by the legislation is the marriage of

health planning and resource development after years of separation under the CHP and RMP programs. Also, the regulatory capabilities of the State Agency provide greater authority than was available to health planners under old programs. The mandated Certificate of Need program will establish uniform mechanism for controlling capital expenditures of health care facilities. Uniform procedures and criteria for reviews required of the HSA and State Agency are also outlined in the legislation.

Provisions for the review and approval or disapproval of proposed uses of federal funds under the Public Health Service Act, the Community Mental Health Centers Act and the Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, add "teeth" to the review and comment function performed by the CHP agencies. It is the first attempt to tie expenditures of federal funds to local health planning goals.

The new law specifies five types of health plans which must be produced. The HSA has the responsibility for producing the Health Systems Plan (HSP), the Annual Implementation Plan (AIP) and a plan which outlines special projects which will achieve the goals of the HSP. The State Agency, with assistance from the State Health Coordinating Council, has responsibility for developing the Medical Facilities Plan and the State Health Plan. Despite the requirements for five different types of plans, the legislation is not specific about what form these plans are to take and how they are to inter-relate. The HSP is described as "a detailed statement of goals describing a healthful environment and health systems in the area which, when developed, will assure quality health services, available and accessible in a manner that assures continuity of care, at a reasonable cost for all residents". /PL 93-641, Section 1513

(a) (2)7. This does not appear to be refinement of the global mission of Comprehensive Health Planning. Regional federal representatives say that model for the HSP will be developed at the federal level to provide guidance to the HSA's, however, the legislation and corresponding regulations are vague regarding the planning functions of both the HSA and the State Agency.

Title XVI, which pertains to Health Resources Development provides grants and loans for the construction, conversion or modernization of facilities. Unlike the Hill-Burton legislation, the emphasis is directed toward supporting the conversion and modernization of existing facilities and the construction of out-patient facilities.

One significant shortcoming experienced in the CHP program which is not adequately addressed through the enactment of PL 93-641 appears to be insufficient funding. Congress successfully overrode President Ford's veto of the health appropriation bill which allotted 90 million dollars for the implementation of PL 93-641. This money will be used for CHP and RMP transition activities and for funding HSA's and State Agencies, National Centers for Health Planning and the National Council on Health Planning. With 201 HSA's, fifty State Agencies and ten Centers for Health Planning to be established nationally, it appears that the first year's funding will be minimal at best.

The most recent estimates cited by the federal represenatives regarding federal allotments for HSA's, suggest that each HSA can expect 23¢-25¢ per capita during conditional designation. Using 1975 estimated population of 748,000 for Montana, the state HSA can expect between

$172,040 and $197,000 in federal funds.[3] Additional funds can be raised locally, although HSA's are restricted from seeking funds from health provider groups in an effort to avoid a potential conflict of interest.

The State Agency funding will include an estimated $200,000 from the federal government. In addition, each state is required to contribute to the cost of operating the State Agency. The State of Montana currently contributes $144,713 to the CHP and Hill-Burton programs. Assuming a combined budget of nearly $350,000, it appears that the State Agency will be in a better financial position than the HSA.

The success of the program will largely depend upon whether the HSA can fulfill the functions required with a minimal budget. In Montana, the situation is aggravated by several factors. The size of the state inflates travel costs for staff and Governing Board members. With 42 persons on the Governing Board, the regular meetings of the HSA will consume a large portion of the budget. Despite the enthusiasm for maintaining the areawide organizations as sub-area councils, it appears unlikely that the HSA will be able to staff these councils. Without staff it is doubtful that these councils can continue. Without sub-area councils, the HSA will lose an important mechanism for developing necessary local input and supporting local decision-making in health care matters.

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[3] While this report was being prepared for printing, the Regional Federal Representatives announced a formula for funding HSA's. Based on the formula, Montana should receive a minimum of $175,000 in operating funds the first year.

Chapter 6

# IMPLEMENTATION OF NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT (PL 93-641) IN MONTANA

Implementation of PL 93-641 is currently in progress in Montana, however, federal funding of the HSA and the State Agency will not occur until the summer of 1976. This report will consider the developments to date and will provide updated information on activities in the form of addendums to the original report.

Federal authorities state there will be 13 sets of regulations promulgated to govern the implementation of PL 93-641. On October 17, 1975, regulations regarding Health Systems Agencies were published in the Federal Register. The regulations establish rules governing the designation of Health Systems Agencies (eg., requirements for eligibility, content of the application, conditional and full designation agreements, etc.) and the issuance of grants to HSA's (e.g., payments, use of grant funds, accountability, etc.). A set of regulations pertaining to State Health Planning and Development Agencies is to be forthcoming. Due to the delay in publishing regulations, Montana's implementation of PL 93-641 has been based on the legislation itself. Revisions may be necessary as federal regulations are brought forth.[4]

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[4]Proposed rules governing State Health Planning and Development Agencies were published March 19, 1976, as this report was in the final stage or preparation. The new regulations do not substantially alter any information contained in this report.

Section I: HEALTH SYSTEMS AGENCY

With the designation of Montana as a single health service area, no single entity existed which could qualify as the Health Systems Agency. In July 1975, two non-profit private corporations were formed with the intention of applying for the designation as the Health Systems Agency. The Montana Health System Agency (MHSA) was formed by representatives of the Montana Medical Association, Montana Foundation for Medical Care and the Montana Hospital Association. Treasure State Health Systems Agency (TSHSA) was formed by representatives of the five areawide health planning councils. Rather than submit competing applications, the two groups chose to combine and submit a single application. By November 1975, the groups has agreed upon a draft set of by-laws for the organization and began to establish a Governing Board. A preliminary board was constituted, including representatives of the existing CHP area-wide councils and various health provider associations. The combined group selected the name Montana Health Systems Agency.

The Governing Board met for the first time on December 12, 1975, when it decided that the MHSA would prepare for Cycle 1 funding and seek formal designation as the state's HSA by March 31, 1976. On November 26, 1975, a notice of intent was filed, formally announcing that the Montana Health Systems Agency planned to submit an application for funding as the HSA for Montana. In accordance with PL 93-641, each prospective HSA applicant is required to hold a public hearing to permit public comment on the proposed application.

On January 9, 1976, a public hearing was held in Helena regarding Montana Health Systems Agency. A brief description of the proposed

structure was given but the application was not available for public review. Comments from those in attendance centered around dissatisfaction with the proposed composition of the Governing Board, suggesions for additions to the Board, and some concern that the Montana Health Systems Agency had not been open to the public in its deliberations. At the conclusion of the meeting, a question was raised pertaining to the legality of holding a public hearing when the proposed application was not available for review. On the following day the MSHA Governing Board voted to postpone the date of submission of the application until April 16, 1976 (Cycle II). The Board also adopted several amendments to the by-laws including the expansion of the Board to 40 members and the establishment of a 16 member Executive Committee.

On February 27, 1976, a meeting of the MHSA Governing Board was held in Helena to review a preliminary draft of the application being submitted to HEW. At this meeting the Governing Board was expanded to 42 members, including an additional Native American and a health insurance representative.

On March 2, 1976, a preliminary draft of the Montana Health Systems Agency (MHSA) application for conditional designation was published for public review. The application outlines the proposed organizational structure of the agency, the proposed work program and the funding requirements for the first year of operation.

The proposed budget was set at $374,000: $243,000 or 65% was allocated to salaries and employee benefits; $13,500 or 3 5% was allocated to equipment; and, $117,500 or 31.5% was allocated to all other direct costs.

The salient features of the application are summarized below.

1. Structure

The MHSA Governing Board consists of 42 members--22 health care consumers and 20 health care providers. Three consumers are selected from each of the five sub-area councils (previously the areawide health planning councils). An additional 7 consumers are appointed from various consumer organizations, (i.e., the Montana United Indian Association, Senior Citizen's Association, Montana Assocition of Counties, etc.) to fulfill the requirement for broad represenation.

Provider representatives are appointed by specified professional associations (e.g., Montana Medical Association, Montana Hospital Association, Montana Nursing Association, etc.). See Appendix C for complete details for the MHSA Governing Board.

The MHSA Governing Board has three standing committees; a 16-member Executive Committee, a Health Systems Planning Committee and a Project Review Committee.

2. Staff

The proposed MHSA staff outlined in the application includes:

Executive Director
Health Planning Manager
Resource Development Manager
Administrative Services Manager
5 sub-area representatives
Clerical staff

3. Sub-area Councils

The MHSA proposes retaining five sub-area councils, one for each of the five planning regions. These sub-area councils will evolve from the existing areawide health planning councils.

According to the application, sub-area councils will serve four primary functions:

1. They are the avenue through which experienced and enlightened consumer Governing Board members are recruited.

2. In a geographic area as large as Montana with its diverse needs and resources, local input is of great value.

3. They provide an organized forum from which the public reviews and comments.

4. Most importantly, they serve as a catalyst for implementing health plans and initiating system change on a local level. (page B-8, MHSA application.)

Each sub-area council will be provided with one staff member and a part-time secretary.

4. Work Program

A. Health Plan Development Functions

The MHSA will review existing health plans and national guidelines for development of the Health Systems Plan (HSP). In addition, a series of informational meetings will be conducted throughout the state to solicit public involvement in the planning effort.

Preparation of the draft HSP is to be followed by a public hearing to solicit public comment on the draft document. The draft HSP is to be completed ten months after the HSA formally initiates its work.* Following the public hearing, the draft plan will be reviewed and approved by the Health Systems Planning Committee and the MHSA Governing Board. By the 12th month of operation, the approved HSP will be submitted to the SHCC, the State Agency and DHEW. The MHSA will prepare an annual implementation Plan (AIP) to detail and prioritize objectives which will meet the goals

*Since activities of the MHSA cannot begin until federal funds are received and the staff is assembled, all deadlines are established in terms of "month of operation" rather than by date.

established in the HSP. The AIP should be completed by the 12th month of the HSA's operation.

The work program states that the MHSA will "work with the State Agency to develop HSP and AIP in mutually acceptable format, and under the same general guidelines", (MHSA work program; p. 3). The application states that "the HSP should represent what the State Agency will consider as the preliminary state Health Plan", (MHSA Conditional Application; D-9).

The MHSA will also assist the State Agency in the development of the State Medical Facilities Plan by "ensuring consistency with HSP-AIP" and "providing comment on specific needs for services and facilities", (MHSA Work Program; p. 3). This activity is scheduled to begin in the 8th month of operation and continue as an ongoing function.

B. Plan Implementation Functions

Plan Implementation involves three major activity categories: 1) transition activities, 2) project review activities, and 3) resource development activities.

Transition activities involve transferring "files, current agreements, criteria and standards for 1122 reviews" from existing 314(b) agencies to MHSA, (MHSA Work Program; p. 5). Based on existing procedures and criteria and Section 1532 of PL 93-641, the MHSA will prepare a project review manual by the 4th month of operation.

Project review activities involve Section 1122 and Certificate of Need reviews, review of existing institutional services to determine "appropriateness", review and approval or disapproval of proposed uses of selected federal funds and the submission of recommendations for the

modernization, construction or conversion of medical facilities.

Section 1122 and Certificate of Need reviews will be established during the first 12 months of operation. MHSA will develop general procedures for conducting these reviews which will be approved by the Project Review Committee and the MHSA Governing Board. Reviews will commence after the State Agency "has provided an analysis of the procedures and criteria...", (MHSA Conditional Application, D-18). MHSA will conduct a limited number of reviews to test the "workability of the review mechanism and criteria", (MHSA Conditional Application; D-18). If the system is found workable, reviews will begin on a regular basis. It is estimated that this activity will commence at approximately the same time period as the completion of the HSP-AIP (10th - 12th month of operation).

The MHSA will not begin formal review and approval or disapproval of proposed uses of federal funds authorized under the Public Health Service Act, the Community Mental Health Centers Act and the Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 until fully designated. During conditional designation the MHSA will review and comment on such proposals.

The review of existing institutional health services will be conducted after full designation (12th - 18th month of operation). Supportive data and other pertinent information will be collected during the conditional period. MHSA will establish procedures for these reviews, conduct the reviews and provide recommendations to the State Agency within 18 months after full designation.

MHSA will establish criteria for making recommendations to the State Agency regarding the modernization, construction or conversion of

facilities. Criteria will be based on appropriate regulations issued by DHEW and consistency with the HSP and AIP. Initial recommendations will be completed approximately 12 months after completion of HSP and AIP.

Resource development activities of the MHSA will generally occur after the development of the HSP and AIP. Prior to such time, the agency staff will increase their knowledge of potential funding sources, application requirements, criteria for qualification, etc. During the second year of funding, MHSA will provide technical assistance to public and private entities to design projects consistent with HSP and AIP. When MHSA is approved by the Secretary of HEW as a fully designated agency, the Area Health Services Development Fund will be established to provide grants and assistance to projects which will attain the goals and objectives of the HSP and AIP. Procedures for the management and operation of the Fund will be developed during the last six months of conditional designation.

C. Data Management and Analysis Functions

MHSA will determine the data requirements of the agency, identify data resources, establish a working mechanism for obtaining necessary information and assemble data into formats for use in planning and review activities. These activities are to be accomplished by the fourth month of operation. Continual updates and analysis of the system will become an ongoing function.

Agency management and support activities proposed by the MHSA include: development of agency policy and procedure, provision of administrative

services, public information mechanisms, development of community relations, staff and committee education and training, and agency review and evaluation.

The MHSA proposed application is still a preliminary document which may be amended by the Governing Board before the April 16, 1976 date for final submission. The Governor will be allowed 30 days to review the application and submit recommendations to HEW. The Secretary of HEW will designate the HSA, after considering these recommendations.

Section 2: STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

The Department of Health and Environmental Sciences has played an important historical role in promoting health planning and resource development in Montana. The Department acted as the 314(a) agency for Comprehensive Health Planning, the Designated Planning Agency under section 1122 of the Social Security Act, the Hill-Burton Agency, and since July 1975, has administered the State Certificate of Need Program. It appears logical that the Department will be designated the State Health Planning and Development Agency once federal regulations governing the designation process are made available. To better prepare for this eventuality, the Department internally reorganized in August of 1975.

The Construction Bureau of the Hospital and Medical Facilities Division has acted as the state Hill-Burton Agency, the Designated Planning Agency under Section 1122 of the Social Security Act and has been responsible for administering the Certificate of Need Program. To fulfill this responsibility the Bureau had maintained liaison with the CHP Division and the five areawide agencies.

The Comprehensive Health Planning Division was primarily responsible

for health planning on a statewide basis, coordinating the five area-wide health planning agencies, and conducting review and comment activities on various health-related programs.

The functions of the State Agency as defined by PL 93-641, combines planning and resource development into a single state agency. The concept of resource development has been expanded to include activities such as the review of institutional services and implementation of planning objectives related to state government. Additionally, PL 93-641 attempts to tie the regulatory activities of resource development more closely to the planning conducted by the HSA and State Agency. However, the law states there should be a separate staff for health planning and for development.

A proposal to combine the old CHP Division with the Construction Bureau to create a Health Planning and Resource Development Division was approved August 8, 1975. The Division has two bureaus; Health Planning, and Resource Development. The functions defined under Section 1523 and Title XVI of PL 93-641 are to be conducted by these Bureaus.

Regulations concerning the State Health and Development Agencies have not been published. Publication is expected in March 1976 for public comment. It appears unlikely that the State Agency will begin to receive federal funding before July 1976. The Health Planning and Resource Development Division remains static pending the publication of the regulations and the completion of the Montana HSA application.

## Chapter 7

# DUPLICATION BETWEEN THE HSA AND STATE AGENCY

The program outlined under PL 93-641, appears to be patterned for urban situations rather than for the needs of the rural areas. The establishment of population restrictions in designating health service areas placed rural states at a disadvantage because of the large geographic area of responsibility. Also, the legislation does not lend itself easily to the situation of a single state HSA. The legislation shows considerable potential for duplication in states with a single HSA and the regulations published to date have not clarified the situation. Examples of potential duplication can be found in nearly all functions required of the HSA and the State Agency. It appears that single state HSA's like Montana will have to develop their own system to de-emphasize the duplication.

### Health Data Management

The legislation specifies the type of health data to be collected and analyzed by the HSA. The HSA is responsible for assembling and analyzing data concerning:

(A) the status (and its determinants) of the health of the residents of its health service area,
(B) the status of the health care delivery system in the area and the use of that system by the residents of the area,
(C) the effect the area's health care delivery system has on the health of the residents of the area, and
(D) the area's health resources, including health services,

manpower, and facilities. /PL 93-641, Section 1513(b)/

In Montana, much of the health data required is unavailable or scattered throughout a number of public and private agencies. Supporting documents accompanying PL 93-641 stress, and the MHSA application reaffirms, that the HSA should not spend an inordinate amount of its resources generating new health data. Yet, it may prove difficult to meet the data requirements of the legislation. The State Agency has a coordinative role in developing a cooperative (federal-state) data system. The HSA and State Agency will need to forge a relationship that assures the most efficient use of resources while meeting minimum requirements for health data.

Plan Preparation

The legislation calls for the development of five planning documents. The HSA is responsible for preparing the Health Systems Plan (HSP) and the Annual Implementation Plan (AIP). These plans are to be the basis for decisions made by the HSA. Also, the HSA must prepare "specific plans and projects for achieving the objectives of the AIP". /PL 93-641, Section 1513 (b) (4)/. Each of these plans is to be statewide in scope. When the plans are approved by the HSA Governing Board, they are submitted to the State Health Coordinating Council (SHCC) and the State Agency. Since 60% of the SHCC membership must come from the HSA, and since the HSA Governing Board approves the HSA plans prior to their submission to the SHCC, the SHCC review may be little more than automatic approval. The State Agency is responsible for preparing the preliminary State Health Plan, to be made up of the "HSP's of the health systems agencies", /PL 93-641, Section 1523(a)(2)/. With one HSA in Montana, the State Health Plan

will only reflect the contribution of one HSP. The preliminary State Health Plan is presented to the SHCC for use in preparation of a final version of the State Health Plan. The State Agency is also responsible for preparing the Medical Facilities Plan. This plan is also presented to the SHCC to assure consistency with the State Health Plan. The requirement for five statewide health plans to be approved by the SHCC is a redundancy in a single state HSA.

Review Activities

The State Agency is responsible for administering the Certificate of Need program for Montana. The HSA must assist in this process by reviewing the need for proposed new institutional health services and making recommendations to the State Agency. The Department of Health and Environmental Sciences is ultimately responsible for issuing the Certificate of Need. The Certificate of Need law has been in effect in Montana since July 1975. The current procedure for administering the program involves the areawide health planning councils. These councils review the projects proposed for their areas and forward recommendations to the Resource Development Bureau for consideration and action. If sub-area councils are established, as proposed by the MHSA by-laws, the procedure will include a review by the sub-area coucils with recommendations sent to the HSA Governing Board for review. The Governing Board's recommendation will be sent to the State Agency for final determination. Without sub-area councils, initial reviews will be conducted at the HSA Governing Board level.

Review and Approval or Disapproval of Selected Federal Funds

The review, approval or disapproval of proposed uses of Federal

funds appropriated under the Public Health Service Act, the Community Mental Health Centers Act, and the Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, is a function required of the HSA Governing Board and SHCC. The published regulations for Health Systems Agencies state that this function may not be performed during the first year of conditional designation. After completing the HSP and AIP, the HSA Governing Board is required to conduct reviews of each proposed use of Federal funds appropriated under the aforementioned Acts (excluding funds to be administered by Indian tribes or inter-tribal organizations). Annually, the SHCC must approve or disapprove "any State Plan or application submitted to the Secretary as a condition to the receipt of federal funds allotted to States" /PL 93-641, Section 1524 (c)(6)/. Since the entire state comprises one health service area, the HSA Governing Board will also review the State Plans and grant applications. This is a duplication of activity and potential source of conflict.

Review of Existing Institutional Services for Appropriateness

To date, there has been no formal guidance from HEW regarding criteria that will be used to determine "appropriateness". Until such clarification is published it is difficult to speculate on the procedure for these reviews. Existing regulations specify that this function cannot be undertaken by an HSA until an HSP and AIP have been developed and approved by the Secretary. When this occurs, the HSA must "...develop and implement a plan for such reviews..." /40 Federal Register 202, II, Section 122.107(15)/. The HSA is required to review all existing institutional services provided within its boundaries. The recommendations of the HSA are to be forwarded to the State Agency. The State Agency is also required

to conduct a review and, after consideration of the HSA recommendations, make public its findings. Based on the limited guidance available, it appears the single State HSA and the State Agency will be conducting the same task.

Implementation Activities

Once the HSP and the AIP have been established and approved, the HSA will be provided with an Area Health Services Development Fund to finance projects which address the priorities established in the AIP. The State Agency is responsible for implementing those parts of the State Health Plan and the plans of the HSA which "relate to the government of the State", /PL 93-641, Section 1523(d)(2)/. The State Agency is not provided with a development fund. This places the State Agency in a position similar to the CHP agencies. Implementation through persuasion was only marginally successful for CHP and was identified as a major shortcoming of the program. Because implementation activities are centered around the establishment of the HSP, AIP and State Health Plan, there will be a significant lag between the termination of the Regional Medical Program (RMP) and the resumption of implementation activities under the new program. Until the passage of PL 93-641, the RMP's had been responsible for implementing a number of programs. On July 1976, the funding for the RMP's expires and a number of programs such as the continuing education programs will use RMP support. There will be a one or two-year wait before implementation funds are available from the Area Health Services Development Fund. This delay may lead to a loss of momentum and expertise painstakingly developed by the RMP's.

# PART III

# FUTURE OPTIONS FOR THE IMPLEMENTATION
# OF THE
# NATIONAL HEALTH PLANNING AND RESOURCE
# DEVELOPMENT ACT IN MONTANA

## Chapter 8

## AVAILABLE OPTIONS FOR

## IMPLEMENTING PL 93-641

Previous chapters have discussed the expectations of PL 93-641 and mentioned some gaps and overlaps in service that can be expected in a state with a single HSA. This part of the report will outline four options in an effort to suggest an efficient structure for conducting the program specified by PL 93-641 in Montana. Because funding levels and designated responsibilities may change, these options pertain to the period of conditional designation and rely on the most recent information available.

The primary functions to be carried out during conditional designation are:

### Health Systems Agency

1. Assemble and analyze health data.
2. Prepare the Health Systems Plan (HSP) and Annual Implementation Plan (AIP)
3. Assist the State Agency in conducting Section 1122 and Certificate of Need reviews.
4. Make recommendations to the State Agency regarding projects for the construction, conversion and modernization of facilities.

### State Health Planning and Development Agency

1. Provide for coordination as part of a cooperative health data system.
2. Prepare the preliminary State Health Plan.
3. Prepare the Medical Facilities Plan.
4. Administer the Certificate of Need Program and act as the Designated Planning Agency for Section 1122 reviews.
5. Administer Title XVI of the Act which involves making grants and loans to priority projects for the construction, converstion and modernization of facilities.

Option #1

This option is predicated on an organizational structure which establishes two distinct and autonomous agencies with separate staffs. This option follows the requirements of the written legislation and accentuates a system of checks and balances between the HSA and the State Agency.

The Health Systems Agency would be responsible for collecting and analyzing health data necessary for developing the Health Systems Plan (HSP) and the Annual Implementation Plan (AIP). The HSA staff would prepare the HSP after considering the national guidelines and the needs of the state. The plan would be reviewed and approved by the HSA Governing Board and presented to the State Agency and the State Health Coordinating Council (SHCC). The AIP would be developed to attain the goals established in the HSP. The plan would be reviewed and approved by the HSA Governing Board.

The HSA would review each proposed new institutional health service and make recommendations to the State Agency regarding the need for such a service. The HSA would conduct such reviews; utilizing procedures and criteria consistent with Section 1532 of PL 93-641, and the established Certificate of Need and Section 1122 (Social Security Act) review procedures.

The HSA would make recommendations to the State Agency regarding priority projects for construction, converstion or modernization in the state.

The State Agency would be responsible for providing coordination with the federal-state cooperative system for the "...collection, retrieval, analysis, reporting, and publication of statistical and other information related to health and health care..." /Section 1522(b)(7)/

The State Agency would prepare the Medical Facilities Plan. Following the completion of the Health Systems Plan of the HSA, the State Agency staff would prepare the preliminary State Health Plan. The preliminary State Health Plan and the Medical Facilities Plan would be presented to the SHCC for approval. The State Agency would administer the Medical Facilities Plan establishing minimum requirements for the maintenance and operation of facilities receiving assistance to all potential applicants, and making grants and loans consistent with the requirements of Title XVI.

The State Agency would take the lead role in the review activities. The State Agency staff would prepare procedures and criteria for reviewing proposed new institutional services required by the State Certificate of Need law and the Agreement with the federal government under Section 1122. The State Agency would consider the recommendation of the HSA and could: 1) accept the HSA recommendation; 2) establish a Review Committee to review the proposal and act on their recommendation; or, 3) conduct a staff review of the proposal and the HSA recommendation to determine if the proposed service is needed. If the State Agency were to make a decision that is inconsistent with the goals of the HSP, the State Agency would be required to submit a detailed statement of the reasons for the inconsistency to the Secretary of Health, Education and Welfare.

Sixty percent of the members of the SHCC would be representatives of

the HSA. The remaining 40% would be appointed by the Governor, consistent with the requirements of Section 1524. This would allow groups not represented on the HSA Governing Board to have an avenue for seeking participation in the health planning of the state. The SHCC would be responsible for: 1) establishing the State Health Plan, based on the Health Systems Plan (HSP) of the HSA and the preliminary State Health Plan prepared by the State Agency; 2) reviewing the budget and grant application of the HSA and making recommendations to the Secretary; and, 3) advising the State Agency generally on the performance of its functions.

One advantage of this type of an organizational structure is the establishment of a system of checks and balances to maintain public accountability through the State Agency and the SHCC for review of the activities of the non-profit private HSA. There would be complete separation of the two agencies and their responsibilities.

The disadvantages of this structure seem to out number the advantages, especially when considering the limited funding available. There would be a greater potential for duplication between the two agencies and the complete separation would eliminate the propitious sharing of resources between the HSA and the State Agency. There is also a greater potential for disagreement between the two agencies. Since both agencies have the same geographic responsibility, disagreements may cause a philosophical split between the two agencies which would be detrimental to the effectiveness of the program.

Another important aspect to consider is the establishment of subarea councils. Given the separation of responsibilities, and the enormous task involved in preparing an HSP, it seems unlikely that the HSA could afford to support sub-area councils on a budget of approximately $175,000.

Without sub-area councils, all decision-making will be centralized and the HSA would lose access to local input.

Option #2

The organizational structure for this option is basically the same as Option 1. However, each agency would have distinct responsibilities which would minimize the potential for duplication in fulfilling the functions required of each agency.

The HSA would be responsible for assembling and analyzing the health data necessary for the preparation of the HSP and AIP.

The non-profit private nature of the HSA lends itself to planning for those health services delivered in the private sector. The HSA staff would develop the HSP and AIP with a focus on improving the private health care delivery system. The plan would be approved by the HSA Governing Board and would be presented to the SHCC.

The State Agency would take the lead role in coordinating the collection of health data relating to state-controlled health services (i.e., health services administered by state government).

The State Agency would limit its planning activities to those pertaining to state-controlled health services. Initially such an effort would begin with those health services provided by state government which will eventually be subject to review and approval or disapproval under Section 1524(b)(6) of Pl 93-641. The State Agency would develop a plan for state health services which would combine with the HSP to become the preliminary State Health Plan.

The State Agency would also prepare the Medical Facilities Plan and

submit it to the SHCC for approval. The State Agency, with the assistance of the SHCC, would administer the approved plan.

The Certificate of Need and Section 1122 Reviews would be conducted as outlined under Option 1.

The SHCC would be composed of sixty percent representatives of the HSA and 40% appointed by the Governor. Because the HSA and the State Agency would undertake different planning responsibilities, the SHCC would be responsible for coordinating the two agencies' activities in the preparation of the State Health Plan. In addition, the SHCC will be responsible for those activities outlined under Section 1524 (summarized under Option 1).

This option provides the advantage of each agency having distinct planning responsibilities which minimize the potential for overlaps or conflicts in planning. The SHCC has a distinct coordinative role and will be instrumental in combining the planning of the HSA and State Agency into a State Health Plan. Finally, a system of coordinated health planning for state-controlled health services, integrated with planning for the private health sector could provide the following beneficial outcomes.

1. A single state agency to provide planning assistance to state departments, divisions, and bureaus responsible for health services.

2. A mechanism for evaluating and improving the health services provided by the state.

3. A mechanism for monitoring the cost and effectiveness of state health programs.

4. The establishment of a plan for state health services to guide policy formulation and decision-making in state government.

This option, like Option 1, does not provide for a sharing of resources. The HSA and State Agency would work independently, and given

the limited budget of the HSA, it is unlikely that sub-area councils can be supported.

Other disadvantages involve the need for cross-departmental cooperation and integration of staff and resources to prepare the plan for state health services. It appears certain that the State Agency will be the Department of Health and Environmental Sciences, administered by the Health Planning and Resource Development Bureau. This may create a problem whereby a division within a department would attempt to plan for programs in other state departments.

## Option #3

Option 3 establishes a functional split in the responsibilities required of the HSA and the State Agency. The HSA staff would assume major responsibility for planning activities while the State Agency staff would assume responsibilities for regulatory or resource development activities. Each agency would concentrate its resources accordingly.

The Executive Committee of the HSA could act as the SHCC for the state to reduce duplication and limit travel expenses. Since the State Agency uses the SHCC as an advisory board, the decisions of the HSA Executive Committee would also be the recommendations to the State Agency.

The HSA would assume full responsibility for assembling and analyzing the health data necessary for fulfilling federal requirements and state health planning requirements. The HSA would prepare the HSP and AIP. The State Agency would contract with the HSA for the preparation of the Medical Facilities Plan and the State Health Plan, which would be a synthesis of the HSP, AIP and Medical Facilities Plan. The State Agency would have a role initially in developing an agreeable planning methodology, but would give the HSA the administrative responsibility for conducting the planning effort. All plans would be reviewed and approved by the SHCC/HSA Executive Committee.

The State Agency would assume responsibility for coordinating the Certificate of Need and Section 1122 reviews. The State Agency would provide funding, using a portion of its Federal allocation, to the sub-area councils to maintain staff for facilitating local reviews.

The State Agency would establish procedures for conducting reviews which would be approved by the HSA Governing Board (or Executive Committee). The sub-area councils would be responsible for following the review procedures established by the State Agency. Recommendations from the sub-area reviews would be approved by the HSA Governing Board (or Executive Committee). The State Agency would make the final determination, consistent with established plans and other criteria.

The State Agency would administer the Medical Facilities Plan, assisted by the SHCC. The State Agency and HSA would jointly establish criteria for determining priority projects for the construction, conversion or modernization of facilities. Based on the criteria, the sub-area councils would recommend priority projects in their sub-area to the HSA Governing Board. The HSA Governing Board would select from these recommendations the priority projects for the State Agency. The State Agency would be responsible for making grants and loans available to those priority projects which meet the established criteria.

The advantage of this option is the ability to fund sub-area councils, while maintaining independent missions for the two agencies. The HSA would concentrate staff on health planning activities, allowing for a maximum health planning staff. The State Agency staff would concentrate on regulatory activities. As staff for reviews, the State Agency would have an opportunity to provide input to the planning effort.

The potential for duplication is eliminated as each agency would concentrate their efforts on distinct functions. This option would maximize the use of funds by providing a mechanism which promotes cooperation and establishes separate functions for the agencies.

This option also would allow for funding of the sub-area councils to assist in the review process. The CHP experience found the areawide health planning councils most useful in coordinating local reviews. This would facilitate reviews, maintain sub-area councils and reaffirm local decision-making.

However, this option is not without its disadvantages. To be successful, this program requires that the HSA and State Agency yield certain responsibilities to the other agency. This requires a similar philosophy regarding health planning and review activities. This may prove to be difficult given the groups involved with the HSA and the past experience of the old state CHP agency.

This option also greatly reduces the need for a Health Planning Bureau within the State Agency and a resource development staff within the HSA which could lead to lopsided expertise in the future.

The sub-area staff would be responsible to a governmental agency for review activities. If the HSA contributes to the sub-areas, the staff would be responsible to a non-profit HSA, for planning activities. This creates a potential for conflict and could result in unjust demands being made on the single staff person in each sub-area.

Finally, this option would have to be approved by HEW. It requires a liberal interpretation of the legislation because some functions required by the HSA would be conducted by the State Agency and vice-versa. Without regulations governing the State Agency it is difficult to determine if this option would be acceptable.

Option #4

This option would utilize a joint HSA/State Agency to fulfill all of the required functions of the two agencies. The ideal situation would be one where the HSA and the State Agency could combine into one entity with one budget and one director. However, the HEW regional representatives have stated that this would not be approved by the Secretary. This option attempts to come as close to a combined agency as possible while maintaining the identity of each agency to satisfy the concerns of HEW. This option requires that the HSA and State Agency be co-located to facilitate joint-staffing arrangements. Co-location would also facilitate the sharing of supplies, clerical staff, equipment and rent.

The SHCC and the HSA Executive Committee would be the same body. This SHCC/Executive Committee would assist in coordinating the two agencies and will be responsible for settling any conflicts between the agencies.

The HSA and the State Agency would jointly determine the health data necessary for preparing the HSP, AIP and Medical Facilities Plan. The HSA Director* would assume the responsibility for coordination with other data sources to facilitate health data accessibility. The State Agency would

*One person must be responsible for supervising the day-to-day activities required for health planning and resource development to assure continuity in the program. It would be up to the HSA and the State Agency to determine which person will be responsible for supervising the various stages involved. Those identified as having supervisory responsibilities in this option are used to illustrate the concept, while practical application may involve different personnel.

contribute staff and financing to help defray the expenses of maintaining an adequate health data management system for the two agencies.

The Health Planning Bureau of the Health Planning and Resource Development Division would work directly with the HSA health planners to prepare the HSP, AIP and the Medical Facilities Plan. When completed, these combined plans would serve as the State Health Plan. After initial consulation with the State Agency to develop a joint planning methodology, the HSA Health Planning Manager would supervise the activities of the joint planning staff and would report the progress to, and seek input from, the HSA Director and the State Agency Administrator. The planning methodology and the plans would be reviewed and approved by the HSA Governing Board. The joint staff, when directed by the HSA Health Planning Manager, would work with the HSA Governing Board, the SHCC/Executive Committee and any other established committees which have responsibilities for health planning. The State Agency would provide the staff of the Health Planning Bureau and would assist in financing the health planning activities (e.g., printing costs, etc.).

The State Agency would be ultimately responsible for administering the Certificate of Need Program and the agreement with the federal government under Section 1122 of the Social Security Act. The HSA and the State Agency would develop a consistent format for conducting reviews. Eventually all reviews would be based upon the State Health Plan which would be jointly prepared. The HSA would provide supportive staff and would share in the expense of conducting reviews. The Resource Development Bureau Chief would coordinate the review process. The State Agency would fund sub-area councils to facilitate coordination between potential

applicants for Certificate of Need and sub-area councils.

After the completion of the Medical Facilities Plan, the State Agency would be responsible for administering the Plan. The sub-area councils would select priority projects from their sub-areas based upon criteria established by the Resource Development staffs of the two agencies. These recommendations would be forwarded to the HSA Governing Board which would select the priority projects for the state and present their recommendations to the State Agency. The joint resource development staff would be responsible for establishing minimum requirements for maintenance and operation of facilities receiving assistance, providing assistance to all potential applicants, and making grants and loans consistent with the requirements of Title XVI.

This option would allow for maximum use of Federal and State funds to support a statewide non-duplicative system for health planning and resource development. A certain flexibility in staffing arrangements would be provided by this option. Staff would be assigned to projects from both agencies as needed, to successfully fulfill the required functions. The program allows for both a centralized and decentralized staff by utilizing the combined resources of both agencies. State Agency personnel would assist in the centralized health planning and resource development which would allow for funding of sub-area staff. This option would provide the advantages of a streamlined planning process as well as the development of a mechanism for local input and decision-making through support of sub-area councils.

The disadvantages of this option center around the close relationship required between a non-profit private agency and an agency of state

government. The HSA may be in a position to offer higher salaries for staff than an agency of state government, which must abide by the Merit System and the Statewide Classification and Pay Plan requirements. This disparity in salaries may present a problem in integrating the staffs.

Given the staffing that exists in the State Agency and the Staffing proposed by the MHSA, there is a potential for too many supervisory positions. It would be necessary to establish clearly defined lines of supervision to avoid conflicts between the staffs. This option may require an intricate system of contracts to maintain adequate management of funds for the two agencies.

Since the Department of Health and Environmental Sciences is the State Agency, it would be necessary that the Governor and the Director of DHES approve the co-location and staff integration of a non-profit private corporation with an agency of state government.

# PART IV

# A P P E N D I X

## Appendix A

### Persons Interviewed in Preparation of Report

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Ms. Ann Gutrals, Director
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Mr. Wallace King, Chief
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Dr. Arthur Knight, MD, FCCP
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Dr. Patrich McCarthy, MD (member of MHSA Executive
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## Appendix B

### Governing Board Composition

/PL93-641, Section 1512(3)(c)/

"(C) Composition--The membership of the governing body and the executive committee (if any) of an agency shall meet the following requirements:

"(i) A majority (but not more than 60 per centum of the members) shall be residents of the health service area served by the entity who are consumers of health care and who are not (nor within the twelve months preceding appointment been) providers of health care and who are broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care.

"(ii) The remainder of the members shall be residents of the health service area served by the agency who are providers of health care and who represent (I) physicians (particularly practicing physicians), dentists, nurses, and other health professionals, (II) health care institutions (particularly hospitals, long-term care facilities, and health maintenance organizations), (III) health care insurers, (IV) health professional schools, and (V) the allied health professions. Not less than one-third of the providers of health care who are members of the governing body of executive committee of a health systems agency shall be direct providers of health care (as described in section 1531(3)).

"(iii) The membership shall--

"(I) include (either through consumer or provider members) public elected officials and other representatives of governmental authorities in the agency's health service area and representatives of public and private agencies in the area concerned with health,

"(II) include a percentage of individuals who reside in nonmetropolitan areas within the health service area which percentage is equal to the percentage of residents of the area who reside in nonmetropolitan areas, and

"(III) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated for such purpose,

and if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of section 1310), include at least one member who is representative of such organizations.

"(iv) If, in the exercise of its functions, a governing body or executive committee appoints a subcommittee of its members or an advisory group, it shall, to the extent practicable, make its appointments to any such subcommittee or group in such a manner as to provide the represenation on such subcommittee or group described in this subparagraph.

## Appendix C

### MHSA - Governing Board

(Article IV of MHSA By-laws)

Section 1 - Composition and Voting Membership: The Governing Board shall consist of twenty (20) representatives from the providers members and twenty-two (22) representatives from the consumers members.

Five (5) physicians licensed by the Montana State Board of Medical Examiners will be appointed by the Montana Medical Association, selected so that one (1) physician will be from each of the five (5) Governor's Administrative Regions. Three (3) hospital administrators one of whom will be a combination facility administrator will be appointed by the Montana Hospital Association, selected in such a manner as to have one hospital administrator from the western sector of the State, one from the central sector, and one from the eastern sector of the State.

One (1) nursing home administrator and/or owner shall be appointed by the Montana Nursing Home Association.

Two (2) registered nurses shall be appointed, with one appointed by the Montana Nurses' Association and one appointed by the Montana League for Nursing.

One (1) dentist shall be appointed by the Montana State Dental Association.

Two (2) third party health care insurers, one of whom shall

be Blue Shield or Blue Cross on an annual rotating basis, and one from the Corporate (private) health care insurers, appointed by the Health Insurance Council.

One (1) representative of health professional schools shall be selected by the Board, with the first year's appointment being the director of the WAMI Medical Education Program in Montana.

Five (5) representatives, one nominated by each of the following allied health care professions, namely: pharmacy, optometry, chiropractic, mental health centers, and one at-large member, elected by the Board of Governors, from the remaining allied health care professions.

Three (3) consumers shall be selected from each of the five (5) Governor's Administrative Regions by vote of all consumer members from that area present at the election. These elections will be initially organized by the existing health planning council in each region and subsequently organized by the sub-area advisory council in each region.

Two (2) Native American consumers; one (1) will be selected on an at-large basis by the Montana members of the Billings Area Indian Health Board and one (1) by the Montana United Indian Association.

Five (5) consumers as follows: one (1) low-income person selected by the Montana Low-Income Association; one (1) senior citizen selected by the Montana Senior Citizens Association; one (1) locally-elected official selected by the Montana Association of Counties; one (1) locally-elected official selected by the Montana League of

Cities and Towns; and one (1) representative from the Governor's staff appointed by the Governor.

The above forty-two (42) members of the Governing Board shall have full voting privileges. No member of the Governing Board shall be permitted an alternate or proxy. The Governing Board shall be representative of the State's population: broad representation of racial, social, economic, geographic metropolitan and rural interests and public elected and appointed officials shall be reflected by Governing Board membership. No person shall use his membership for purpose of private gain.

Section 2 - Ex-Officio Membership: The Governing Board shall also invite to its meeting and grant speaking, but not voting privileges, to the following: (1) the Director of the State Department of Health and Environmental Science, and one (1) a representative from the Veterans' Administration.

# REFERENCES

1. Montana Health Systems Agency, Conditional Application and Work Program, March 2, 1976.

2. Public Law 79-725, Hospital Survey and Construction Act of 1946.

3. Public Law 88-443, Hospital and Medical Facilities Amendments of 1964.

4. Public Law 89-239, Heart Disease, Cancer and Stroke Amendments of 1965.

5. Public Law 89-749, Public Health Services Amendments of 1966.

6. Public Law 91-296, Medical Facilities Construction and Modernization Amendments of 1970.

7. Public Law 92-603, Social Security Amendments of 1972.

8. Public Law 93-45, Health Program Extension Act of 1973.

9. Public Law 93-641, National Health Planning and Resource Development Act of 1974.

10. Report by the Committee on Interstate and Foreign Commerce, Report Number 93-1382, September 26, 1974.